

Statement of Deficiencies  
Citation Summary Sheet

PRINTED: 04/11/2011

**For: STONEBROOKE REHABILITATION CENTRE & SUITES ( 155160 / 000080 )**  
**Survey Event: 74W911, Exit Date 04/07/2011**

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	FF07	12.00	00	0000	INITIAL COMMENTS	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155160</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>STONEBROOKE REHABILITATION CENTRE &amp; SUITES</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>990 N 16TH ST</b> <b>NEW CASTLE, IN 47362</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00088549.</p> <p>Complaint IN00088549- Substantiated with no deficiencies related to the allegation cited.</p> <p>Survey date: April 6, and 7, 2011</p> <p>Facility number: 000080 Provider number: 155160 AIM number: 100289330</p> <p>Survey team: Barbara Gray, RN-TC</p> <p>Census bed type: SNF: 10 SNF/NF: 68 Total: 78</p> <p>Census payor type: Medicare: 10 Medicaid: 60 Other: 8 Total: 78</p> <p>Sample: 3</p> <p>Stonebrooke Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00088549.</p> <p>Quality review completed on April 8, 2011 by Bev Faulkner,RN</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.